Department of Health and Human Services
Health Care Financing Administration
Operational Policy Letter #129

Date:	**November 22, 2000**	
To:	**Current M+C Organizations**	**X**
	CHPP Demonstrations:	
	-- Evercare	
	-- DoD (TriCare)	
	-- SHMO I & II	
	-- PACE	
	-- Medicare Choices	
	OSP Demonstrations:	
	-- MSHO	
	-- W.P.S.	
	HCPPs	
	Federally Qualified HMOs	
	Section 1876 Cost Plans	
Effective Date:	**January 1, 2001**	
Implementation Date:	**January 1, 2001**	

Subject:

1) Year 2001 National Project on Congestive Heart Failure (CHF) for Medicare + Choice Organizations (M+CO); and 2) Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care.

Purpose:

The purpose of this Operational Policy Letter (OPL) is to provide an overview and requirements for M+COs on two separate congestive heart failure (CHF) quality efforts beginning on January 1, 2001. The first, the National QISMC Congestive Heart Failure Quality Assessment and Performance Improvement (QAPI) project, is required of all M+COs. Under the national QAPI project, all M+COs will utilize the two quality

indicators described below to demonstrate improved quality of care. The second section of this OPL sets forth criteria that will apply in qualifying for extra payment in recognition of the costs of successful outpatient CHF care. For this effort, M+COs desiring extra payment for eligible heart failure patients must meet certain thresholds for two quality indicators for all eligible patients. What follows are descriptions of these efforts.

A. The National QISMC Congestive Heart Failure Quality Assessment and Performance Improvement (QAPI) project.

As stated in the Medicare + Choice Final Rule and the Quality Improvement System for Managed Care (QISMC) Interim Standards and Guidelines, Medicare + Choice (M+C) managed care organizations (M+COs) are required by contract to complete two Quality Assessment and Performance Improvement (QAPI) projects per year, one of which is on a topic chosen by HCFA while the other project may be one of each organization's own choosing. For the year 2001, the national project to be initiated is to address congestive heart failure (CHF).

According to the American Heart Association, approximately 3,000,000 Americans are currently diagnosed with CHF. Of these, over 80% (2,400,000) are over the age of 65, most being Medicare enrollees. The one-year mortality rate for CHF is between 20-30% in the elderly. CHF patients also experience significant functional limitations. Recent studies suggest effective clinical treatments and disease management strategies which may be effective in improving patient function, reducing mortality rates, decreasing hospital admissions and improving overall patient quality of life.

The QISMC National CHF QAPI project will be similar in many ways to the previous diabetes and pneumonia national efforts. M+COs will identify the relevant patient population, perform baseline data collection and calculate the baseline values for the selected quality indicators. They will then design and implement improvement strategies, and perform follow-up indicator data collection and measurement.

However, there are aspects to this National CHF QAPI project which differ from previous projects. This project requires that M+COs measure and report performance on two specified quality indicators instead of one, and HCFA will review the outcome on each indicator. M+COs will be expected to achieve demonstrable improvement, which is a 10% reduction in the performance gap, on the second indicator (QAPI #2).

As with the 1999 and 2000 national QISMC projects, some organizations may have existing projects that could be modified to meet the requirements of the national CHF project. Those organizations wishing to utilize projects currently underway may do so if: (1) they follow the requirements of Domain 1 in QISMC;

(2) utilize the CHF quality indicators as described herein, and (3) conduct a re-measurement in 2001 to establish a new baseline against which to assess their improvement.

National CHF QAPI Quality Indicators

HCFA has developed the quality indicators based on evaluation and treatment recommendations contained in the Agency for Health Care Policy and Research (AHCPR) Clinical Practice Guideline Number 11, Heart Failure: Evaluation and Care of Patients with Left-Ventricular Systolic Dysfunction (AHCPR Publication No. 94-0612, June 1994), the American College of Cardiology/American Heart Association Task Force Report Guidelines for the Evaluation and Management of Heart Failure (*JACC* 1995;26:1376-98), and the Heart Failure Society of America Guidelines for Management of Patients with Heart Failure Caused by Left Ventricular Systolic Dysfunction—Pharmacological Approaches (*J Cardiac Failure* 1999;5:357-82).

The indicators are also based on experience gained from the design and implementation of quality indicators for HCFA's inpatient National Heart Failure Project and the pilot outpatient Heart Failure Performance Improvement Effort, which utilized expert input from an American Heart Association Work Group. Additionally, HCFA utilized the principles and recommendations contained in the report of an American Heart Association/American College of Cardiology work group "Evaluating quality of care for patients with heart failure. A summary from the First Scientific Forum on Quality of Care and Outcomes Research in Cardiovascular Disease and Stroke." *Circulation* 2000;101: e122-e140. The indicators have been previously tested by HCFA for feasibility of data collection in the outpatient setting, reliability, and acceptability of the measure to providers. Finally, we received input from M+COs, physicians and trade associations throughout this process to help refine the design and selection of the quality indicators.

The two QISMC National CHF QAPI quality indicators are:

- ***QAPI #1* = Proportion of CHF patients with assessment of left ventricular function;**
- ***QAPI #2* = Proportion of CHF patients with left ventricular systolic dysfunction (LVSD) who (1) have been prescribed an angiotensin-converting enzyme inhibitor (ACEI); *or* (2) have documentation of a reason why ACEI was not prescribed.**

Appendix I contains more detailed measurement specifications for the CHF indicators.

Use of Alternative CHF Indicators

At their option, if a M+CO has a baseline level above a certain level on both quality indicators, it may design and use an alternative quality indicator. Quality indicator baselines will be established by HCFA after input from a national clinical expert panel and announced by January 1, 2001 on our website at 'www.hcfa.gov'. Prior to proceeding to use an alternative indicator, however, M+COs must provide information to HCFA Regional Office (RO) managed care staff demonstrating that they have met the required baseline levels. RO staff will in turn work with the HCFA Office of Clinical Standards and Quality in assisting the M+CO in the design of the alternative indicator. M+COs are encouraged, although not required, to also work with their state PRO.

Regardless of the choice of alternative indicator, the selected measure must meet the following requirements:

- **Indicator should affect M+COs Medicare enrollees.**
- **Indicator should be measurable.**
- **Indicator should reflect the QISMC National CHF QAPI goal of reducing morbidity and mortality associated with congestive heart failure.**

Technical Support for the QISMC National CHF QAPI Project

HCFA encourages M+COs to work in collaboration with their state Peer Review Organizations (PROs) in the design and implementation of their QAPI CHF projects. In the event that the M+CO chooses not to utilize the PRO, questions regarding design and implementation should be directed to the HCFA Regional Office managed care staff.

We note that, as in prior years, if the M+CO works cooperatively with the PRO on quality improvement projects, HCFA will pay the PRO and/or Clinical Data Abstraction Centers (CDACs) the costs of abstracting information from the M+CO medical records. In addition, if the medical records need to be photocopied prior to abstraction by the PRO/CDAC, the M+CO's cost of such photocopying will be reimbursed by HCFA through the PRO.

HCFA is developing an optional data collection instrument for use in data abstraction. This will include data specifications, e.g. words and phrases that indicate LVEF assessment and LV systolic dysfunction. It will also include lists of ICD-9-CM and CPT codes likely to indicate that LVF was assessed. These optional tools will be available to all M+COs regardless of who performs data abstraction. They will be posted to our web page at www.hcfa.gov.

Please send any questions regarding this OPL/ Congestive Heart Failure QAPI project to your Regional Office managed care staff, or to: Judith L. Bragdon, MS, RN, (410) 786-1037 in HCFA's Center for Health Plans and Providers, Health Plan Administration office.

Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care

The current M+CO risk adjustment payment methodology for CHF, the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model, is based upon inpatient hospitalization discharge diagnoses. Recent studies strongly suggest that excellent outpatient management of CHF may decrease hospitalization rates and improve quality of life for CHF patients. In response to industry concerns, and specifically trying to work within current data constraints, HCFA has developed a payment mechanism for recognizing and paying for the costs of this successful outpatient CHF care. To qualify for extra payment in 2002, M+COs will identify enrollees who have been hospitalized for CHF during a prior two-year period and measure the success in treating these enrollees via two designated quality indicators. M+COs achieving threshold levels on both quality indicators will receive extra payment.

Requirements for M+COs to Qualify for Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care

1. **Definition of CHF Diagnosis. Extra payments for CHF will be based on enrollees with a greater than one day stay for a principal inpatient discharge diagnosis of CHF. Currently, the CHF diagnosis codes are the following, although these codes are subject to change: 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 428.x.**

2. **Two required quality indicators. M+COs seeking the extra payment must measure two quality indicators for the entire CHF population described in # 3 below. No alternative quality indicators may be substituted for the two quality indicators. The required quality indicators are:**

    1. **Proportion of M+CO enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure, and who have evaluation of left ventricular function as of October 1 of the reporting year.**

    2. **Proportion of M+CO enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure, and who have left ventricular systolic dysfunction (LVSD) and, as of October 1 of the reporting**

year: 1. are prescribed angiotensin converting enzyme inhibitors (ACEI); OR 2. have documented reason for not being on ACEI .

Additional information on the required quality indicators for extra payment may be found in Attachment I. (quality indicators "EP1" and "EP2")

3. Designated Measurement Population.

For payment in 2002: The population for which the required quality indicators will be measured must consist of M+CO enrollees who have been continuously enrolled in the plan for a minimum of 180 days prior to October 1, 2001 who were discharged from an acute care hospital between 7/1/99 and 6/30/01 with a greater than one-day stay for a principal inpatient discharge diagnosis of CHF (regardless of whether the enrollee was a member of the M+CO at the time of the hospitalization). Where information on an inpatient hospital discharge has been received by HCFA, HCFA will flag enrollees with CHF diagnoses codes, as defined in #1 above, on Monthy Membership Reports to M+COs to assist them in identifying the designated measurement population.

For payment in 2003: The population for which the required quality indicators will be measured must consist of M+CO enrollees who have been continuously enrolled in the plan for a minimum of 180 days prior to October 1, 2002 who were discharged from an acute care hospital between 7/1/99 and 6/30/02 with greater than a one-day stay for a principal inpatient discharge diagnosis of CHF (regardless of whether the enrollee was a member of the M+CO at the time of the hospitalization). Note that the beginning discharge date for payment in 2003 is the same as the beginning discharge date for payment in 2002 (7/1/99) so that M+COs can continue to manage the health care of those hospitalized between 7/1/99 and 6/30/00 as well as those hospitalized between 7/1/00 through 6/30/02. Where information on an inpatient hospital discharge has been received by HCFA, HCFA will flag enrollees with CHF diagnoses codes, as defined in #1 above, on Monthly Membership Reports to M+COs to assist them in identifying the designated measurement population.

4. Thresholds must be met.

The M+CO must meet threshold levels on both quality indicators in order to qualify for the extra payment. Quality indicator threshold levels will be established by HCFA after input from a national clinical expert panel. The practical challenges of measuring the two quality indicators and/or meeting the thresholds will be taken into consideration. The thresholds will be announced by HCFA in the "Advance Notice of Methodological Changes in

Medicare+Choice Payment Rates for Calendar Year (CY) 2002", to be published on January 15, 2001.

5. Reporting.

<u>For payment in 2002</u>: M+COs shall report to HCFA on or after October 1, 2001 for payment in 2002. (Attachment II provides a draft format for reporting, pending OMB approval). Paper copies of the reports should be sent to the attention of Angela Porter, Health Care Financing Administration, Mailstop C4-13-01, 7500 Security Blvd, Baltimore, MD 21244. The report must include the following:

a) M+COs must submit a brief (e.g. two-page) description of their strategies and processes (e.g. disease management program) for managing the care of the designated CHF population.

b) M+COs who have more than 400 enrollees with the CHF diagnosis as in #1 above, may sample their population to achieve a sample size of at least 400. The sample must be representative of the population. HCFA expects that few M+COs will have sufficient CHF enrollees to sample their CHF population for reporting. M+COs doing sampling must report their sampling methodology on the attached reporting form (pending OMB approval).

c) The M+CO must report its performance (including numerator, denominator, and proportion) on both of the required quality indicators as of October 1, 2001. The report must be submitted before 1/31/02 to qualify for payment in 2002. For each member of the designated population, M+COs must maintain records of the Health Insurance Claim (HIC) numbers and whether the member appears in the numerator and denominator for each measure. In the event that the M+CO is subject to an audit, the M+CO must furnish beneficiary-level results for both of the quality indicators in a format to be designated by HCFA (see #7 below).

Depending upon when M+COs report their performance, HCFA will make payment in one of two waves: For reports received from M+COs between 10/1/01 and 11/30/01, extra payment will be made to qualifying M+COs no later than 90 days after 11/30/01. Extra payments will be retroactive to 1/1/02. For reports received from M+COs between 12/01/01 and 1/31/02, extra payment will be made no

later than 90 days after 1/31/02. Extra payments will be retroactive to 1/1/02. Consistent with the risk adjustment payment system, extra payments will be made on a monthly basis. M+COs must not report their performance any later than 1/31/02 for extra payment in 2002.

<u>For payment in 2003</u>: M+COs shall report to HCFA on or after October 1, 2002 for payment in 2003. (Attachment II provides a draft format for reporting, pending OMB approval). Paper copies of the reports should be sent to the attention of Angela Porter, Health Care Financing Administration, Mailstop C4-13-01, 7500 Security Blvd, Baltimore, MD 21244. The report must including the following:

a) M+COs must submit a brief (e.g. two-page) description of their strategies and processes (e.g. disease management program) for managing the care of the designated CHF population.

b) M+COs who have more than 400 enrollees with the CHF diagnosis as in #1 above, may sample their population to achieve a sample size of at least 400. The sample must be representative of the population. HCFA expects that few M+COs will have sufficient CHF enrollees to sample their CHF population for reporting. M+COs doing sampling must report their sampling methodology on the attached reporting form (pending OMB approval)

c) The M+CO must report its performance (including numerator, denominator, and proportion) for both of the required quality indicators as of October 1, 2002. The report must be submitted before 1/31/03 to qualify for payment in 2003. For each member of the designated population, M+COs must maintain records of the HIC number and whether the member appears in the numerator for each measure. In the event that the M+CO is subject to an audit, the M+CO must furnish these beneficiary-level results for both of the quality indicators (see #7 below).

Depending on when M+COs report their performance, HCFA will make payment in one of two reporting waves: For reports received from M+COs between 10/1/02 and 11/30/02, extra payment will be made to qualifying M+COs no later than 90 days after 11/30/02. Extra payments will be retroactive to

1/1/03. For reports received from M+COs between 12/01/02 and 1/31/03, extra payment will be made no later than 90 days after 1/31/03. Extra payments will be retroactive to 1/1/03. Consistent with the risk adjustment payment system, extra payments will be made on a monthly basis. M+COs must not report their performance any later than 1/31/03 for extra payment in 2003.

6. **Extra payment. Assuming the M+CO's report on quality indicators shows attainment of the required threshold levels for both quality indicators, extra payments will be made to the M+CO in 2002 for each enrollee who was discharged from an acute care hospital between 7/01/99 and 6/30/00 with a greater than one-day stay for a principal inpatient diagnosis of CHF and who are enrolled in the M+CO at the beginning of each payment month in 2002. In 2002, M+COs with enrollees hospitalized with a greater than one-day stay for a principal diagnosis of CHF between 7/01/00 and 6/30/01 will receive the full PIP-DCG-16 amount under the risk adjustment payment methodology. The extra payment to qualifying M+COs for those enrollees discharged between 7/1/99 and 6/30/00 will be based on approximately one-third the full PIP-DCG-16 amount, subject to the risk adjustment transition schedule. Assuming a payment blend of 80% demographic payment and 20% risk adjusted payment in 2002, the additional payments to qualifying M+COs would be based approximately on the following formula: .33 (one third of PIP-DCG 16 amount) X 2.4 (PIP-DCG-16 risk factor) X .20 (the payment blend in 2002) of the risk adjusted county rate.**

   Payments will be made to a qualifying M+CO in 2003 for each enrollee who was discharged from an acute care hospital between 7/01/99 and 6/30/02 with a greater than one day stay for a principal inpatient diagnosis of CHF and who are enrolled in the M+CO at the beginning of each payment month in 2003. M+COs with enrollees hospitalized with a principal diagnosis of CHF between 7/01/01 and 6/30/02 will receive the full PIP-DCG-16 amount under the risk adjustment payment methodology. Extra payment to qualifying M+COs will be for those enrollees discharged between 7/1/99 and 6/30/01 and will be based on a portion of the full PIP-DCG-16 amount. The extra payment amount for 2003 will be determined in 2001 and announced in the January 15, 2002 "Advance Notice of Methodological Changes in Medicare+Choice Payment Rates for Calendar Year 2003."

7. Auditing. For payment years 2002 and 2003, a sample of M+COs will be selected for auditing of the submitted data. Upon notification, M+COs must submit beneficiary level information for the numerator and denominator for each quality indicator, as outlined in #5 above. For example, M+COs must maintain records of the HIC number and whether the member appears in the numerator for each measure. (i.e. for each HIC number: LVF evaluation: yes/no, LVSD, yes/no; ACEI for LVSD: yes/no/not indicated). Using this information and other administrative data, HCFA will identify a sample of medical records. For M+COs with more than 400 with the CHF diagnosis as in #1 above who use sampling, HCFA may choose to review the sampling methodology and/or audit medical records of those who were or were not sampled. HCFA will review medical records or other supporting documentation to verify the quality indicator rates. If the review fails to confirm that the M+CO met both of the quality indicator thresholds, then HCFA will recover all associated payments from the M+CO.

8. Hospitalization Tracking. HCFA will track re-hospitalization rates for those enrollees for which the M+CO is receiving additional payments. The M+COs are encouraged to track readmission rates as a means of monitoring their success in preventing re-hospitalization in this population.

Questions about the Extra Payment in Recognition of the Costs of Successful Outpatient Care

Assistance from the PROs is not available to M+COs for any data collection and abstraction performed solely for extra payment in recognition of the costs of successful outpatient CHF care. For questions regarding the requirements for this extra payment, please contact Jane Andrews at HCFA's Center for Health Plans and Providers, Demonstrations and Data Analysis Group, (410) 786-3133.

Attachment I

QAPI Quality Indicators for Heart Failure

NB: **Both quality indicators must be measured and reported to HCFA.**

Quality Indicator QAPI 1:**Proportion of heart failure patients with assessment of left ventricular function**

Population:	**M+CO enrollees with a continuous enrollment of at least 180 days prior to the date of data collection, who have encounter/billing diagnoses of heart failure in the inpatient or outpatient settings, including:** **a) those enrollees discharged alive from an acute care hospital with a principal discharge diagnosis of heart failure[1] in the one year prior to the date of data collection; as well as:** **b) those enrollees without a hospital principal discharge diagnosis of CHF, but with three or more physician encounters with a diagnosis of CHF[2], in the one year prior to the date of data collection.**
***Denominator*:**	**A census or random sample of M+CO enrollees from the 'Population' as defined above.**
***Numerator*:**	**Those in denominator with documentation that left ventricular function (LVF) have been evaluated. Documentation of LVF evaluation consists of a billing record indicating that LVF evaluation has been performed, quantitative or qualitative lab report of LVF evaluation results, clinician notation that LVF evaluation has been performed, clinician notation of LVF results, or any other chart or administrative evidence that LVF evaluation has been performed.**
Data Sources:	***Enrollees with heart failure:*** **Enrollment data, billing data, encounter data, hospital discharge data, any other reviewable source.** ***LVF evaluation:*** **Billing data, radiology or laboratory data, medical records, physician summary, any other reviewable source.**

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[1] ICD-9-CM codes: 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 428.x

[2] See footnote 1.

Quality Indicator QAPI 2: **Proportion of heart failure patients with left ventricular systolic dysfunction (LVSD) who:**

1. are prescribed angiotensin converting enzyme inhibitors (ACEI); *OR*
2. have documented reason for not being on ACEI

Population: **Those in numerator of QAPI Quality Indicator 1 with left ventricular systolic dysfunction (LVSD). LVSD is defined as an ejection fraction less than 40% or equivalent narrative description[3]**

Denominator: **A census or random sample of M+CO members from the 'Population' defined above.**

Numerator: **Those in denominator who have**

(1) Been prescribed ACEI; OR
(2) Chart documentation of one or more of the following contraindications to ACEI use:
- **moderate or severe aortic stenosis, OR**
- **history of angioedema, hives, or severe rash with ACEI use; OR**
- **bilateral renal artery stenosis; OR**

(3) Chart documentation of any specific reason why ACEI is not used (e.g., cough, hyperkalemia, hypotension, renal insufficiency/failure, other physician-noted reason); OR
(4) Chart documentation of participation in a clinical trial testing alternatives to ACEIs as first-line heart failure therapy.

Data Sources: ***LVF evaluation results (quantitative or qualitative):*** **Radiology or laboratory test results, medical record, physician summary, any other reviewable source.**
Prescription of ACEI: **Pharmacy data, medical records, physician summary, any other reviewable source.**
Reason for not prescribing ACEI: **Inpatient or outpatient diagnosis codes, medical record, any other reviewable source.**
Participation in a clinical trial testing ACEI alternatives: **any reviewable source**

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[3] A list of qualitative descriptions from laboratory reports or clinician notes considered consistent with LVSD will be provided prior to Jan. 1, 2001.

QUALITY INDICATORS FOR EXTRA PAYMENT
IN RECOGNITION OF THE COSTS OF SUCCESSFUL OUTPATIENT CARE

***Quality Indicator EP1*:** **Proportion of M+CO enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure, and who have evaluation of left ventricular function as of October 1 of the reporting year.**

Population: **M+CO enrollees with a principal inpatient discharge diagnosis of congestive heart failure[4] with a greater than a one-day stay who are continuously enrolled for at least 180 days prior to and including date of reporting (October 1), and:**

- **For reporting on October 1, 2001, were discharged between July 1, 1999 and June 30, 2001**
- **For reporting on October 1, 2002, were discharged between July 1, 1999 and June 30, 2002.**

***Denominator*:** **Same as 'Population.' M+COs with greater than 400 enrollees in this population may perform a random sample of the eligible population, measuring no fewer than 400 enrollees.**

***Numerator*:** **Those in denominator who have documented left ventricular function (LVF) evaluation on or before October 1 of reporting year. Documentation of LVF evaluation consists of a billing record indicating that LVF evaluation has been performed, quantitative or qualitative lab report of LVF evaluation results, clinician notation that LVF evaluation has been performed, clinician notation of LVF results, or any other chart or administrative evidence that LVF evaluation has been performed.**

Data Sources:

Enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure:

Where information on inpatient hospital discharges has been received by HCFA, HCFA will flag enrollees with CHF diagnosis codes on the Monthly Membership Reports to M+COs; M+COs may have other internal sources of this data, as well.

LVF evaluation: **Billing data, radiology or laboratory reports, medical records, physician or disease management summary, any other reviewable source.**

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[4] ICD-9-CM codes: 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 428.x

***Quality Indicator EP2*:** **Proportion of M+CO enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure, and who have left ventricular systolic dysfunction (LVSD) and, as of October 1 of reporting year:**

1. are prescribed angiotensin converting enzyme inhibitors (ACEI); *OR*

2. have documented reason for not being on ACEI.

Population: **Those in numerator of Quality Indicator EP1 with left ventricular systolic dysfunction (LVSD). LVSD is defined as an ejection fraction less than 40% or equivalent narrative description.[5]**

***Denominator*:** **Same as 'Population.' M+COs with greater than 400 enrollees in this population may perform a random sample of the eligible population, measuring no fewer than 400 enrollees.**

Numerator: **Those in denominator who, as of October 1 of reporting year have**

(1) Been prescribed ACEI; OR

(2) Chart documentation of one or more of the following contraindications to ACEI use:

- **moderate or severe aortic stenosis, OR**
- **history of angioedema, hives, or severe rash with ACEI use; OR**
- **bilateral renal artery stenosis); OR**

(3) Chart documentation of any specific reason why ACEI is not used (e.g., cough, hyperkalemia, hypotension, renal insufficiency/failure, other physician-noted reason); OR

(4) Chart documentation of participation in a clinical trial testing alternatives to ACEIs first-line heart failure therapy

Data Sources: ***LVF evaluation results (quantitative or qualitative):*** **Laboratory test reports, medical record, physician summary, any other reviewable source.**

Prescription of ACEI: **Pharmacy data, medical records, physician summary, any other reviewable source.**

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[5] A list of qualitative descriptions from laboratory reports or clinician notes considered consistent with LVSD will be provided prior to Jan. 1, 2001.

Reason for not prescribing ACEI: **Inpatient or outpatient diagnosis codes, medical record, physician summary, any other reviewable source.**
Participation in a clinical trial testing ACEI alternatives: any reviewable source.

Attachment II

REPORT OF PERFORMANCE ON QUALITY INDICATORS TO QUALIFY FOR EXTRA PAYMENT IN RECOGNITION OF SUCCESSFUL OUTPATIENT TREATMENT OF CHF

Note: This report is draft pending approval by the Office of Management and Budget.

Instructions:

This report applies only to M+COs that are applying for extra payment in recognition of the costs of successful outpatient CHF care. Definitions to be used in this report are provided in section B of the CHF OPL. Established threshold levels for these quality indicators may be found in the "Advanced Notice of Methodological Changes in the Medicare+Choice Payment Rates for Calendar Year (CY) 2002", published on January 15, 2001.

Contact Name_____ **H-Number**_____

M+CO Name_____

Telephone Number_____ **Fax Number** _____

I. Quality Indicator EP1:

A. Number of M+CO enrollees with principal inpatient discharge diagnosis of congestive heart failure (CHF) with a greater than a one-day stay during index time frame.

_____

B. Number of M+CO enrollees with a greater than one day stay for a principal inpatient discharge diagnosis of CHF during index time frame who had, as of October 1 of reporting year, evaluation of left ventricular function (LVF)

_____

C. Proportion (defined as B/A) _____

II. Quality Indicator EP2:

D. Number of M+CO enrollees with a greater than one day stay for a principal inpatient discharge diagnosis of CHF during index time frame who had left ventricular systolic dysfunction (LVSD) _____

E. **Number of M+CO enrollees with a greater than one day stay for a principal inpatient discharge diagnosis of CHF during index time frame and documented LVSD who are either prescribed angiotensin converting enzyme inhibitors (ACEI) or have a documented reason for not being on ACEI as of October 1 of reporting year. _____**

F. **Proportion (defined as E/D)_____**

Notes: You should review your submission. Note that the number placed in 1.B should be less than the number placed in 1.A. The number in 2.D should also be less than 1.B. The number in 2.E should be less than 2.D.

Sampling

For M+COs with greater than 400 enrollees with a diagnosis of CHF who have sampled their population (your sample size should be no smaller than 400 enrollees), describe your sampling methodology.

Description of CHF Disease Management

Attach a brief description (e.g., two pages) of the strategies and processes (e.g., disease management program) for managing the care of the designated CHF population

Return report no later than January 31, 2002 to:

Angela Porter

Center for Health Plans and Providers

HCFA, C4-13-01

7500 Security Boulevard

Baltimore, MD 21244-1850

Or

aporter@cms.gov
